HCFA MEDICARE • MEDICAID Health Care Financing Administration

Volume IV, Number 10 June 1999

HEALTH watch

Medicare Provider Payment Updates on Schedule for 2000

Despite initial concerns that Y2K priorities might delay scheduled Medicare updates for doctors, hospitals and other providers in fiscal year and calendar year 2000, the Health Care Financing Administration (HCFA) announced recently that payment updates will be made in October and mid-January as long as Year-2000 readiness efforts continue on track.

"HCFA's top priority between now and January 1, 2000 is to make sure that Medicare computer systems are Y2K compliant so that Medicare beneficiaries' care is uninterrupted and that providers' claims are paid in a timely fashion," HCFA Administrator Nancy-Ann Min DeParle said. "At the same time, HCFA wants to meet statutory deadlines for making routine payment updates for providers, and I'm pleased that we're now on track to meet both goals."

We've made excellent progress on Y2K readiness, and our success means we can make the provider payment updates without jeopardizing our systems.

See **Updates,** page 3

Medicare Announces New Administrative Process for National Coverage Decisions

To ensure Medicare beneficiaries have access to the latest effective, evidence-based treatments, the Health Care Financing Administration (HCFA) recently issued new administrative procedures designed to make the national coverage decision process more open, understandable and predictable.

"This will be the most open and accountable process for making national coverage decisions in the history of Medicare," HCFA Administrator Nancy-Ann Min DeParle said. "Creating an understandable and predictable process for national coverage decisions is a critical step in preparing Medicare for the 21st century."

Administrative Process

The administrative process was published in the April 27 *Federal Register* as a notice. It outlines how the public may request national coverage decisions, timelines for reviewing requests and the roles of HCFA staff, the Medicare Coverage Advisory Committee and technology assessments in national coverage decisions. The notice, which will soon be posted on the Internet at ***http://www.hcfa.gov/quality/8b.htm***, also details methods to keep the public informed about the status of coverage reviews and outlines how the agency will reconsider coverage decisions based on new scientific and medical information.

"We have been working for more than a year with representatives of the medical community, beneficiaries and medical-device manufacturers, listening to ideas and discussing how to improve Medicare's national coverage process," said Jeffrey Kang, M.D., director of HCFA's Office of Clinical Standards and Quality. "The end result of this work will be an improved process that will help ensure beneficiaries have access to the latest effective technology."

Broad Coverage

The Medicare law provides for broad coverage of many medical and health care services, including care provided by hospitals, skilled-nursing facilities, home-health agencies and physicians. Instead of providing an all-inclusive list of items and services covered by Medicare, the Congress gave the Health and Human Services Secretary the authority to decide which specific items and services within these categories can be covered by Medicare.

The law also states that Medicare cannot pay for any items or services that are not "reasonable and necessary" for the diagnosis and treatment of illness or injury. For more than 30 years, the Medicare program has exercised this authority to determine

See **Decisions,** page 3

HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

NANCY-ANN MIN DEPARLE
Administrator

ELIZABETH CUSICK
Acting Director, Office of Communications & Operations Support

JOYCE G. SOMSAK
Director, Communications Strategies & Standards Group

HEALTH WATCH TEAM

JON BOOTH.....410/786-6577
JUSTIN DOWLING.....617/565-1261
WILLIAM KIDD.....Relay: 800/735-2258
410/786-8609
MILDRED REED.....202/690-8617
DAVID WRIGHT.....214/767-6346

Visit Our Web Site!
www.hcfa.gov

You may browse past issues of the *HCFA Health Watch* at ***www.hcfa.gov/news/newsltrs/newsltr.htm***. Also, should you wish to make an address change, or comment on an article, send your e-mail to ***healthwatch@hcfa.gov***.

Message from the Administrator

NANCY-ANN MIN DEPARLE

BUILDING ON THE CLINTON ADMINISTRATION'S campaign against Medicare waste, fraud and abuse, the Health Care Financing Administration selected a dozen companies to help us protect the Medicare Trust Fund.

These new companies — the first-ever Medicare Integrity Program contractors — have broad experience and expertise in conducting audits, performing medical reviews and tackling other essential tasks. Their selection represents a new way for Medicare to partner with the private sector to ensure that beneficiaries and taxpayers get their money's worth from Medicare.

In the past, Medicare by law had to rely solely on the private insurance companies that pay and process Medicare claims to conduct program integrity activities. The Health Insurance Portability and Accountability Act of 1996 gave Medicare new authority to contract with more types of businesses to do that essential work.

The 12 chosen contractors include technology and accounting businesses as well as some current Medicare contractors. Together, they offer a broad range of skills to prevent honest errors and unscrupulous practices.

As you know, the Clinton Administration's commitment to root out waste, fraud and abuse in the Medicare program has proven successful.

These efforts, which involve HCFA, the HHS Inspector General, the Department of Justice, and other federal, state and private partners, have returned $1.2 billion to the Medicare Trust Fund in the past two years. Medicare has cut its error rate roughly in half during the same period, according to the Inspector General's annual program audits.

The latest audit credits the improvement to the administration's anti-fraud and abuse efforts; HCFA's corrective action plan; and improved compliance by hospitals, doctors and other health-care providers.

But we all know that we must do more to ensure that Medicare dollars are spent only on legitimate services for our 39 million seniors and other beneficiaries. These special program safeguard contractors are an important part of that effort.

HCFA has issued the group's first six assignments, which include auditing cost reports for large national health-care chains, expanding provider education efforts, and other tasks to prevent and reduce improper Medicare payments. The contractors will bid on those assignments, and the chosen companies will start work over the summer.

These assignments supplement the work already being done by Medicare's existing contractors. HCFA will issue additional work orders in the future to target areas that can strengthen Medicare's integrity.

We know that most health-care providers want what we want — fair reimbursement for providing quality care to the elderly, disabled and other Americans that rely on Medicare. These contractors will help us achieve that goal, helping us keep Medicare strong today and in the future. ◆

Updates, from page 1

Following the recommendation of its Y2K expert consultant, known as an independent verification and validation (IV &V) contractor, HCFA announced last summer that provider payment updates might be delayed to minimize computer system changes during final Y2K testing and monitoring. After reviewing the status of the renovation and testing of systems with its IV&V contractor, HCFA has determined that the solid progress made on Y2K preparations will allow provider payment updates to occur in a timely manner.

"We've made excellent progress on Y2K readiness, and our success means we can make the provider payment updates without jeopardizing our systems," DeParle said.

To insure Medicare claims are paid promptly and accurately after January 1, 2000, HCFA is now requiring that all electronic claims be Y2K compliant. As of April 16, almost 100 percent of Part B claims submitters and more than 90 percent of Part A claims submitters were filing Y2K-compliant claims with eight-digit date fields. HCFA is working with industry trade groups to bring the compliance rate to 100 percent for Part A and B claims.

Throughout the summer and fall, HCFA and its contractors will continue to test and retest their computer systems. Beginning in July, all HCFA systems will undergo an extensive recertification process.

By law, Medicare payment updates for Part A providers, including inpatient hospitals, skilled-nursing facilities, home-health agencies and hospices are supposed to occur on October 1 of each year, while payment updates for physicians and other Part B providers and suppliers are supposed to occur on January 1 of each year.

Because of the Y2K compliance status of contractor systems, HCFA is now expecting to make Part A payment updates on October 1, 1999, but to minimize system disruptions, there will be no changes in ICD-9-CM codes (International Classification of Diseases, 9th Revision, Clinical Modification) for fiscal year 2000.

HCFA expects to make Part B payment updates on January 17, 2000, but will

See **Updates,** page 5

Decisions, from page 1

whether specific services that meet one of the broadly defined benefit categories should be covered under the program.

Most Medicare coverage and policy decisions are made locally by HCFA contractors — the private companies that by law process and pay Medicare claims. HCFA also makes coverage policies that apply nationwide and are binding on all HCFA contractors and administrative law judges.

Under the new administrative process, HCFA will initiate national coverage reviews when appropriate and accept formal requests from external parties for coverage decisions.

The agency typically will initiate a national coverage review when there are conflicting local contractor coverage policies, a service represents a significant medical advance and no similar service is covered by Medicare, there is substantial disagreement among medical experts about a service's efficacy or medical effectiveness, or the service is currently covered but is widely considered ineffective or obsolete.

External Requests

Formal external requests for a national coverage decision must be in writing, contain a complete description of the item or service in question, a compilation of the medical and scientific information currently available, a description of any clinical trials or studies currently underway, and in the case of a drug, device or service using a drug or device regulated by the Food and Drug Administration (FDA), the status of FDA administrative proceedings. Once HCFA determines that a formal external request contains all requested information, the agency will accept the formal request and initiate a series of internal timeframes to ensure that requests are processed in a timely manner. HCFA will ordinarily respond in writing to the requestor within 90 calendar days of accepting a complete request. If the requestor submits additional medical and scientific information during this 90-day period, however, the agency will ordinarily respond within 90 calendar days of receiving the additional information. The agency's response will include, at a minimum, one of the following:

Response(s)

- A national coverage decision without limitations on coverage.
- A national coverage decision with limitations on coverage.
- No national coverage decision, which allows for local contractor discretion.
- A national non-coverage decision, which precludes local contractors from making payment for the item or service.
- A referral to the Medicare Coverage Advisory Committee.
- A referral for a technology assessment.
- A decision that the request duplicates another pending request and will be combined with the other request.
- A decision that the request duplicated an earlier request that has already been decided and there is insufficient new evidence to reconsider the request.

If a referral is made to the Medicare Coverage Advisory Committee, HCFA will ordinarily make a decision within 60 days of receiving the committee's recommendation. If a technology assessment is required, the timeline for HCFA's coverage decision will be extended, but the agency does not expect that technology assessments would normally take longer than 12 months to complete.

Throughout the coverage decision process, HCFA will publish a list of coverage issues under review, the stage of review each issue is in, and an estimate of when the next action will occur. This list will be available on HCFA's Web site at ***www.hcfa.gov***

See **Decisions,** page 4

Fraud and Abuse Executive Seminars

In keeping with the goal of working in partnership with the states, the Medicaid Fraud and Abuse National Initiative sponsored a series of executive seminars recently. The seminars were designed to provide senior level federal agencies such as the HHS Office of Inspector General, the Department of Justice, the FBI, the Administration on Aging, and HCFA Central and Regional Offices as well as state decision-makers with tools to develop and implement innovative strategies to better combat fraud and abuse in their respective Medicaid programs.

HCFA contracted with Dr. Malcolm Sparrow of Harvard University's John F. Kennedy Graduate School of Government to conduct a series of four seminars. Dr. Sparrow, a nationally recognized authority in the emerging discipline of health care fraud control, has conducted extensive research over a period of years in the field. He compiled and presented much of this research in his groundbreaking book, *License to Steal: Why Fraud Plagues America's Health Care System*. This book remains the definitive work in the field of health care fraud control and is recommended reading.

Each seminar ran for 2.5 days and included an intensive case-study driven program designed to highlight weaknesses and vulnerabilities in both traditional fee-for-service and managed care programs. The program was highly interactive, with a focus on strategies and solutions.

The series consisted of four seminars covering the states in HCFA's Southern, Midwestern, Western, and Northeastern consortia. At the conclusion of the final session, health care professionals from 49 states, the District of Columbia, and three territories attended this unique training. ◆

Rhonda Hall who works in the Atlanta Regional Office contributed this article. She is the national coordinator of HCFA's Medicaid Fraud and Abuse Initiative.

Decisions, from page 3

and will enable anyone interested in a coverage issue to determine quickly whether an item or service is under review, the current status, anticipated actions and approximate deadlines, as well as the major scientific questions that need to be resolved prior to a coverage decision.

HCFA also will develop a record for each coverage decision, including a list of all evidence reviewed, all the major steps taken in the coverage review, and the rationale for the coverage decision. A summary of this record will be provided on HCFA's Web site. Additionally, HCFA will reconsider coverage decisions at any time when new medical and scientific information becomes available or the requestor can demonstrate that HCFA materially misinterpreted the evidence submitted with the original request. HCFA's next step to make national coverage decisions more open, predictable and understandable will be to publish a proposed rule explaining the general criteria used to evaluate medical items and services for national coverage decisions. The proposed rule, which is scheduled to be published this summer and will have a public comment period, also will explain the general criteria used to determine whether items and services are reasonable and necessary and the types of evidence needed for a national coverage decision.

Once finalized in regulation, the coverage criteria will serve as a framework to develop sector-specific guidance documents to further explain how the criteria apply to specific health care sectors such as diagnostic devices, durable medical equipment or biologics. ◆

growth

The Children's Health Insurance Plan (CHIP) anticipates providing health insurance coverage for more than 2.5 million currently uninsured children by October 2000.

Calendar of Speaking Engagements

June 16	Administrator Nancy-Ann Min DeParle speaks at Health on Wednesday in Washington, D.C., on hot topics HCFA is currently addressing, the status of federal legislative initiatives affecting HCFA and issues that HCFA will need to consider in the next several years.
June 24	Administrator DeParle addresses the National Committee on Vital and Health Statistics in Washington, D.C., on priorities for health information for HCFA and the Department.
July 22	Deputy Administrator Michael Hash speaks at the National Patient Advocate Foundation in Washington, D.C., on the ambulatory patient charges regulations and mandated self-administerables.

Selected Health Issues on the Web

http://aspe.hhs.gov/health/reports/transition/welfare.htm

Supporting Families in Transition. A Guide to Expanding Health Coverage in the Post-Welfare Reform World

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 replaced the old Aid to Families with Dependent Children (AFDC) with a new state-run Temporary Assistance for Needy Families (TANF) program and ended the automatic link between eligibility for cash assistance and eligibility for Medicaid. This guide serves three major purposes: first, it assists state policymakers and others in understanding program and policy areas. Second, it discusses the Medicaid requirements and options that apply in three common scenarios, and third, it points the reader to the various sources of funding that are available to states to pay for low-income families with dependent children.

http://www.consumersunion.org/

White Knights or Trojan Horses? A Policy and Legal Framework for Evaluating Hospital Consolidations in California

This is a report on the history of nonprofit acute-care hospitals converting to for-profit status in California from 1993 to 1998. Click on "Health" when you get to this Consumers Union home page at the above URL.

http://www.gao.gov/new.items/he99091.pdf

Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues

The Government Accounting Office, a resource of Congress, submits the above titled report under HEHS-99-91. It contains 53 pages plus 5 appendices of 16 pages, dated April 27, 1999. You can find the report in Portable Document File format. Any individual report may be retrieved directly from the archive in text and PDF formats with the following URL: ***http://www.gao.gov/cgi-bin/getrpt?RPTNO***, replacing RPTNO with the report number (e.g., GAO/OCG-98-1).

http://www.house.gov/writerep

Government in Action

Would you like to write to your representative in Congress? This site will help you.

More Browsing...

A few more Web sites that should be of interest to seniors are:

www.aarp.org

The American Association of Retired Persons Web site has a lot of information of interest to seniors.

www.intelihealth.com

Experts at Johns Hopkins provide information on health-related topics, with links to other major health sites. ◆

Updates, from page 3

apply the updates retroactively to all claims for services provided on or after January 1. Also, all typical coding changes will occur on January 17 for Part B services and will be retroactive to January 1.

Providers can file claims as usual, but Medicare contractors will hold all claims with dates of service of January 1 or later until January 17 to make sure the year 2000 payment updates and any changes in beneficiary coinsurance and deductibles, which take effect January 1, are installed and applied correctly. ◆

United Government Services to Process Medicare Part A Claims for Va. and W.Va.

The Health Care Financing Administration (HCFA) announced on May 24, 1999, that United Government Services will replace Trigon Insurance Company as the Medicare contractor processing Part A claims for Virginia and West Virginia.

Part A contractors process claims for hospitals and other providers under contract with HCFA, which runs the Medicare program. United Government Services will process claims for 530 health care facilities in the two states. Since Part A contractors process claims for hospitals and other providers, care for seniors, the disabled and other Medicare beneficiaries will not be affected by this change.

Trigon advised HCFA in early May 1999 of its decision to end its participation in the Medicare fee-for-service program. The selection of United Government Services was made in consultation with the Blue Cross and Blue Shield Association.

The Milwaukee-based company will maintain offices in Virginia and West Virginia. Health care providers in Virginia and West Virginia who send Medicare bills to Trigon will see no changes in service as United Government Services assumes the fiscal intermediary function for these states.

The transition to United Government Services will be completed by mid-August 1999. ◆

New Regulations/Notices

Medicare Program; Medicare Coordinated Care Demonstration Project and Request for Information on Potential Best Practices of Coordinated Care [HCFA–1100–N] — Published 3/23. This notice announced HCFA's intent to conduct the Medicare Coordinated Care Demonstration. It informed interested parties of the opportunity to submit information on examples of best practices of coordinated care, as well as comment on potential aspects of the overall Medicare Coordinated Care Demonstration. Section 4016 of the Balanced Budget Act of 1997 requires a review of best practices and, following this assessment, a Medicare Coordinated Care Demonstration to be launched by August 1999. The purpose of the demonstration is to evaluate models of coordinated care that improve the quality of services furnished to specific beneficiaries and reduce expenditures under Part A and B of the Medicare program.

Medicare Program; Meetings of the Negotiated Rulemaking Committee on Ambulance Fee Schedule [HCFA–1002–N] — Published 3/26. This notice announces the dates and location for the second meeting and the dates for the third and fourth meetings of the Negotiated Rulemaking Committee on the Ambulance Fee Schedule. These meetings are open to the public. The purpose of this committee is to develop a proposed rule that establishes a fee schedule for the payment of ambulance services under the Medicare program through negotiated rulemaking, as mandated by section 4531(b) of the Balanced Budget Act of 1997. The second meeting was scheduled for April 12 and 13, 1999 from 9 a.m. until 5 p.m. and April 14, 1999 from 8:30 a.m. until 4 p.m. E.S.T. Two further meetings aree scheduled for May 24 and 25, 1999 and June 28 and 29, 1999.

Medicare Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 1999 [HCFA–2032–N] — Published 3/29. The Social Security Act provides for the Medicaid program to pay all or part of the Medicaid Part B premiums for beneficiaries belonging to two specific eligibility groups of lowincome Medicare beneficiaries referred to as Qualifying Individuals (QIs). This notice announced the federal fiscal year 1999 allotments that were provided for State agencies to pay Medicare Part B premiums for these two eligibility groups. This document is defined as a major rule under the congressional review provisions of 5 U.S.C. section 804(2). As indicated in the preamble of this notice, pursuant to section 5 U.S.C. section 808(2), for good cause we find that prior notice and comment procedures are unnecessary and impracticable. Pursuant to 5 U.S.C. section 808(2), this notice is effective October 1, 1998, for allotments for payment of Medicare Part B premiums for individuals in calendar year 1999 from the allocation for fiscal year 1999.

Medicare Program; April 23, 1999 Open Town Hall Meeting to Discuss the Skilled Nursing Facility Prospective Payment System (SNF/PPS) and Quality of Care in Nursing Facilities [HCFA–1071–N] — Published 4/8. This notice announced a Town Hall meeting to provide an opportunity for nursing homes, beneficiary advocates, and other interested parties to ask questions and raise issues regarding the prospective payment system for skilled nursing facilities and the quality of care in nursing facilities. The meeting represened sone aspect of the evolving process for making our payment, coverage and quality reviews more open and responsive to the public. The meeting addressed the following topics: 1. An update and future refinements for the skilled nursing facility/ prospective payment system including a discussion of nontherapy ancillary services and consolidated billing; 2. Outpatient therapy caps and other Part B issues; 3. Skilled nursing facility coverage and medical review; 4. Nursing home enforcement and quality issues. This meeting took place on April 23, 1999 from 8:00 a.m. to 5:00 p.m., E.S.T. ◆

Department of Health & Human Services
Health Care Financing Administration
7500 Security Boulevard, Mail Stop C5-15-07
Baltimore, Maryland 21244-1850

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

First Class Rate
Postage & Fees
PAID
HHS Permit No. G-28